

MONTHLY PROGRESS REPORT ★ SECTION

7

HEALTH



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# HEALTH

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## SUMMARY

NONEFFECTIVE RATES Noneffective rates continue to be exceptionally favorable in all areas. About 202,000 Army patients were in hospital and quarters during January. Of these, 63 percent were either overseas or had been evacuated to Z/I hospitals. (See pages 2 and 3)

ADMISSION RATES Hospital admissions in the United States were relatively unchanged during February but a slight increase occurred overseas in January as had been observed earlier in the Z/I. Part of the increase in theater rates resulted from higher incidence of venereal infection. (See pages 4 and 5)

RESPIRATORY DISEASE OVERSEAS The present respiratory season is extremely favorable overseas. An outbreak of influenza B in the civilian population of the United Kingdom during January and early February had no parallel in the small Army force stationed there. Rates for the Third Army, and for the small troop concentrations in the Berlin and Bremen areas, however, have been high. (See page 6)

HEALTH OF ARMIES OF OCCUPATION Relatively favorable morbidity rates are being reported for troops in Japan and Korea as well as for those in Germany and Austria, the major exception being in the incidence of venereal disease. In general, the admission rates for occupation troops are similar to those for the rest of the troops in the theater. (See page 7)

DISEASE HAZARDS IN BASIC TRAINING CENTERS It is well known that certain disease hazards are greater among "raw" recruits than among seasoned troops, but current disease rates, particularly for streptococcal infections, are unusually high at certain basic training centers. (See pages 8 to 9)

MALARIA The latest admission rates for malaria are below ten per 1,000 men per year in all theaters except the Western Pacific and Asiatic. With the cessation of routine atabrine suppression in the Western Pacific on 1 November the rate advanced from 24 to 35. The maintenance of troops under garrison conditions makes it possible to reduce the chance of malarial infection to such a low level by the use of anti-mosquito measures that routine use of atabrine suppression is no longer desirable. The chances are excellent that better drugs than atabrine will become available. (See pages 10 and 11)

VENEREAL DISEASE OVERSEAS The venereal disease picture is still one of continuously rising rates overseas. Even in the Western Pacific, where the rate had been on the decline, venereal disease rose suddenly during November. In the Mediterranean some improvement was noted in January among the white troops, and there was a slight recession in the Z/I. (See page 12)

HOSPITALIZATION OVERSEAS By 31 January there had already been effected 87 percent of the reduction which will be necessary to reduce the bed capacity overseas on 30 April 1945 to the estimated requirements on 30 June 1946. Similarly the number of beds authorized had been reduced by 94 percent and the number of occupied beds had fallen by a similar proportion, more than keeping pace with the strength reduction of 89 percent by 31 January. Only 28,800 beds were occupied overseas on 31 January, representing 39 percent of the operating capacity. (See pages 14 to 16)

HOSPITALIZATION IN THE Z/I Patients in general and convalescent hospitals declined by 21,000 during February to about 96,000 at the end of the month. The planned closing of general and convalescent hospitals during the first quarter of 1946 will involve the transfer of about 5,000 patients who will need treatment beyond that date. In addition to the patients in general and convalescent hospitals there were about 31,000 patients in regional and station hospitals on 28 February, or 75 percent of the authorized capacity. (See pages 18 to 20)



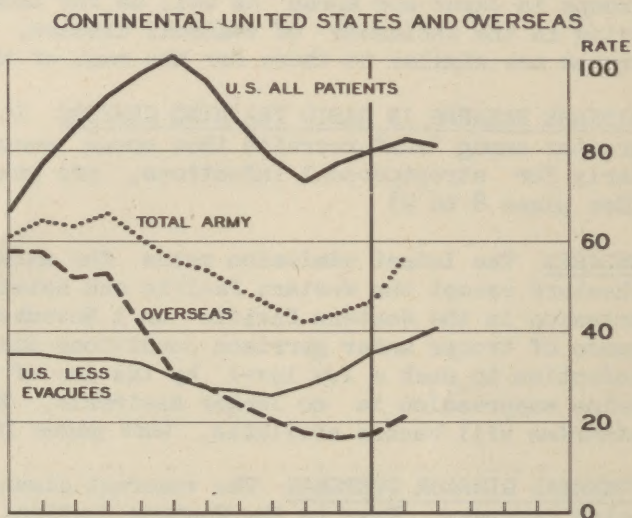
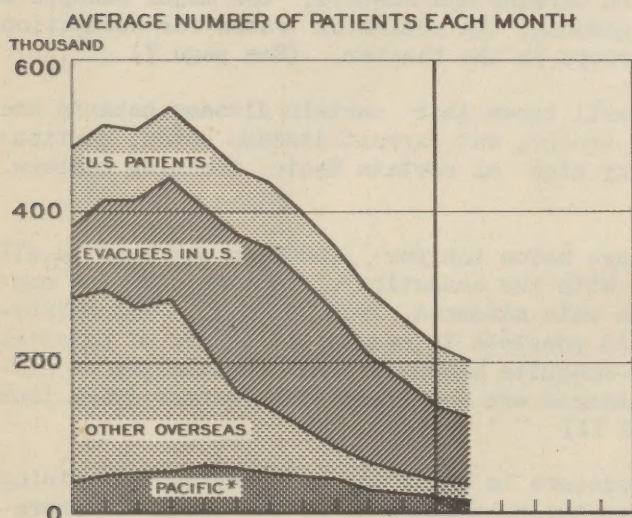
# DISEASE AND INJURY

## NONEFFECTIVENESS IN HOSPITAL AND QUARTERS

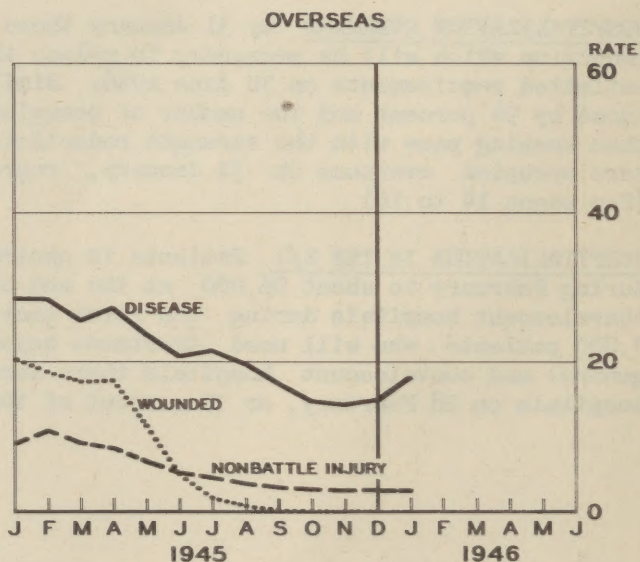
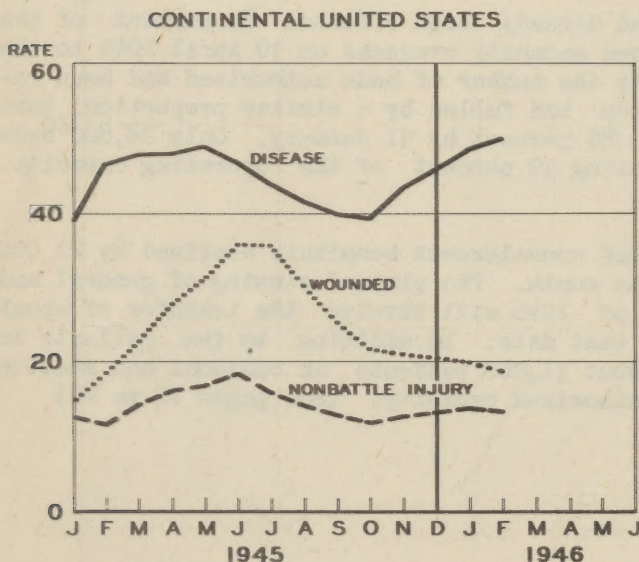
Moderate seasonal increases characterize the latest noneffective rates overseas, but in the Z/I the rise in the corrected rate for February apparently reflects changes in strength, as there was virtually no change in the admission rate. The noneffective population itself continues to decline. During January, Army patients in hospital and quarters averaged about 202,000, or 22,000 fewer than in January. About 39,000 were overseas and of the 163,000 in the Z/I 89,000 were evacuees. In other words, 63 percent of all Army patients in hospital and quarters were either overseas or had been evacuated from overseas. During the month of February there were about 33,000 wounded and 9,500 neuropsychiatric patients among the noneffectives in the U. S.

## AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

### ALL CAUSES



### MAJOR CAUSES



\* Middle and Western Pacific



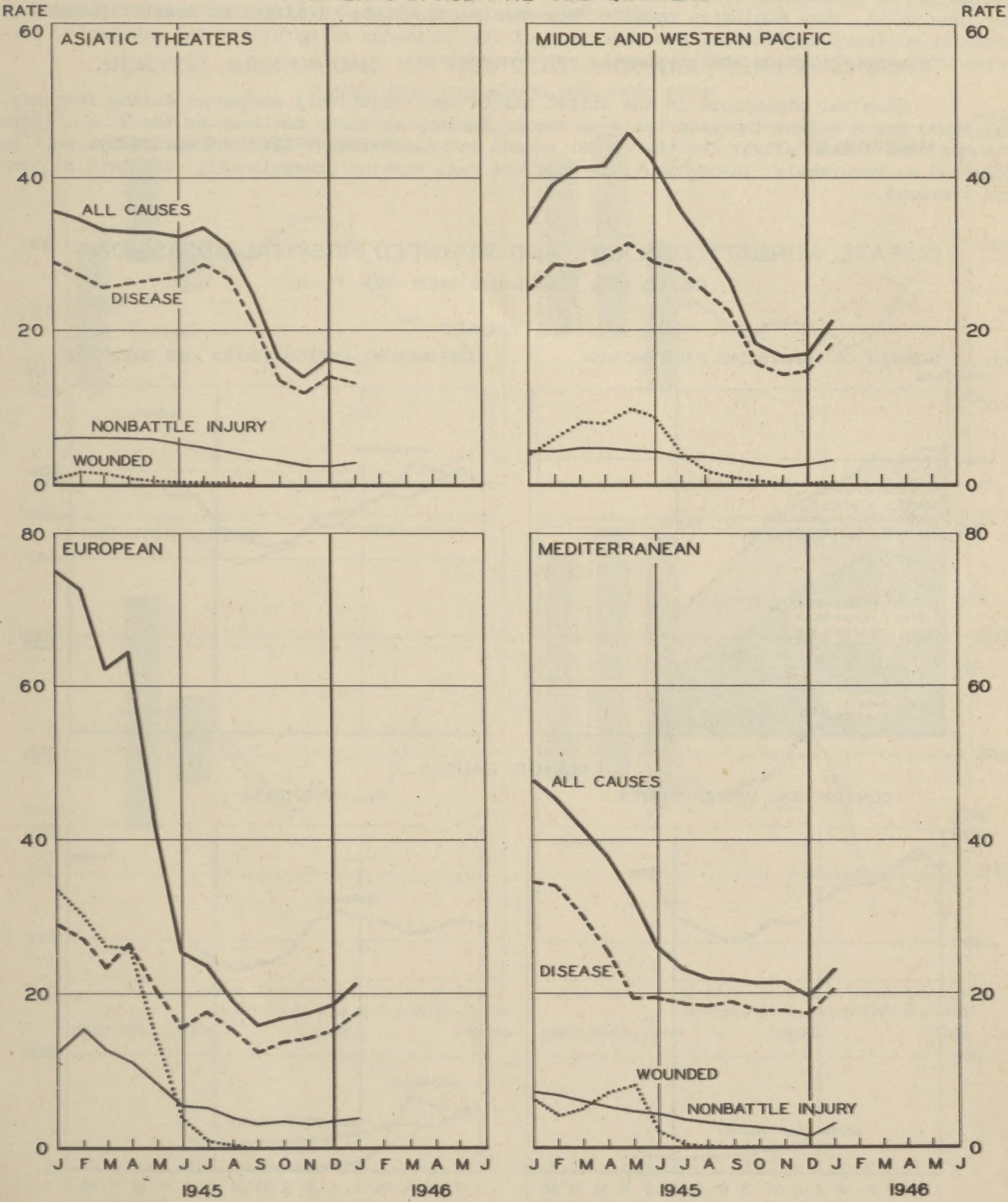
# DISEASE AND INJURY

## NONEFFECTIVES IN HOSPITAL AND QUARTERS (Continued)

In response to rising admission rates the noneffective rates of major theaters increased slightly in January. Rapidly falling strengths forbid close comparison of noneffective trends, but it is plain that noneffective rates are being maintained at exceptionally low levels, and particularly so in view of the season in most theaters.

### AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

#### PATIENTS IN HOSPITAL AND QUARTERS





# DISEASE AND INJURY

## TREND OF HOSPITAL ADMISSIONS IN THE UNITED STATES AND OVERSEAS

Admission rates are less subject to bias from rapid fluctuations in strength than are noneffective rates. They tend to be artificially low only in the face of such factors as the medical screening which often precedes large troop movements and the organization of task forces for combat. As indicators of trends in morbidity, noneffective rates are less sensitive, for the noneffective count includes all the sick, injured, or wounded regardless of date of admission. Hence the noneffective rate may be sharply reduced by evacuation, or increased by a rapid loss of strength without evacuation of parallel extent, even without any change in the incidence of disease or injury. This does not mean that noneffective rates are any less valid than admission rates. They merely constitute a different health measure of peculiar military importance, the resultant of the incidence of morbidity and accidents, policies of hospitalization and treatment, and evacuation.

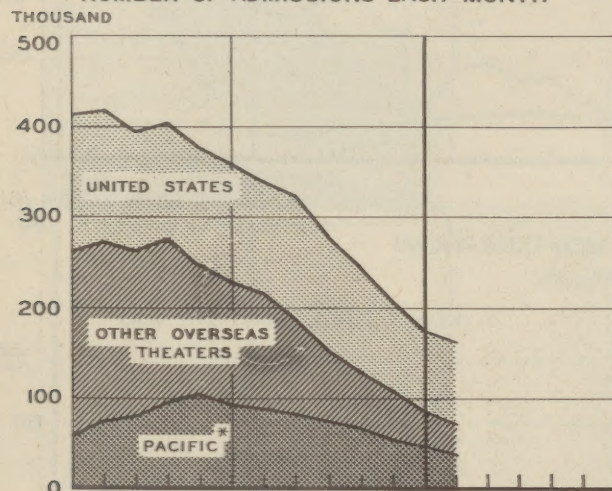
Hospital admissions in the United States were relatively unchanged during February, but there was a slight increase overseas during January as there had been in the U. S. These changes are indeed slight for the winter season and the current level of morbidity must be regarded as remarkably favorable. The accident rate remains exceptionally low both at home and overseas.

## DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS

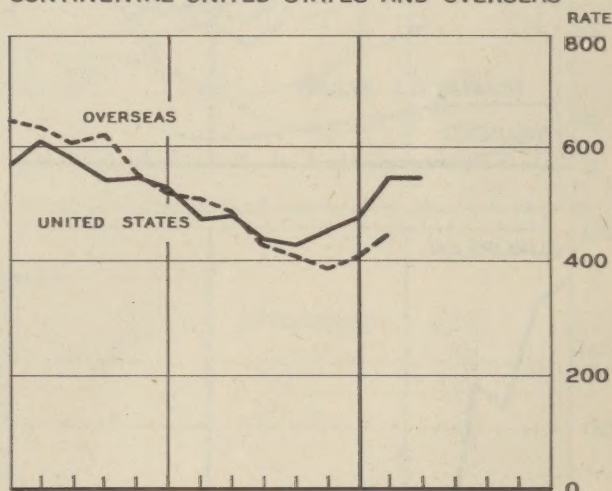
### RATES PER THOUSAND MEN PER YEAR

#### ALL CAUSES

##### NUMBER OF ADMISSIONS EACH MONTH

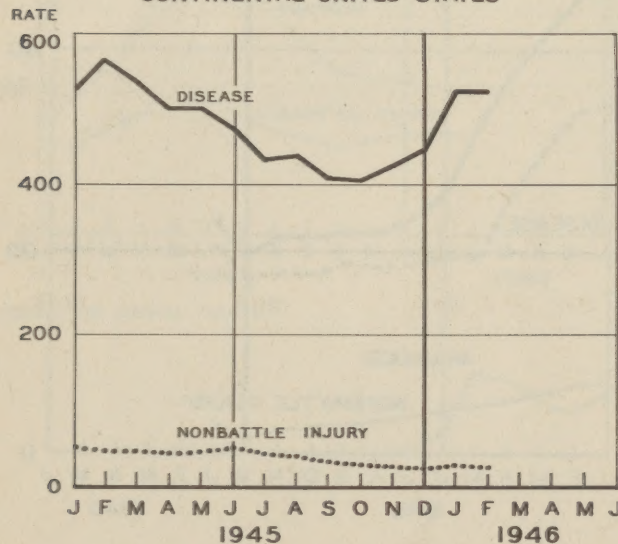


##### CONTINENTAL UNITED STATES AND OVERSEAS

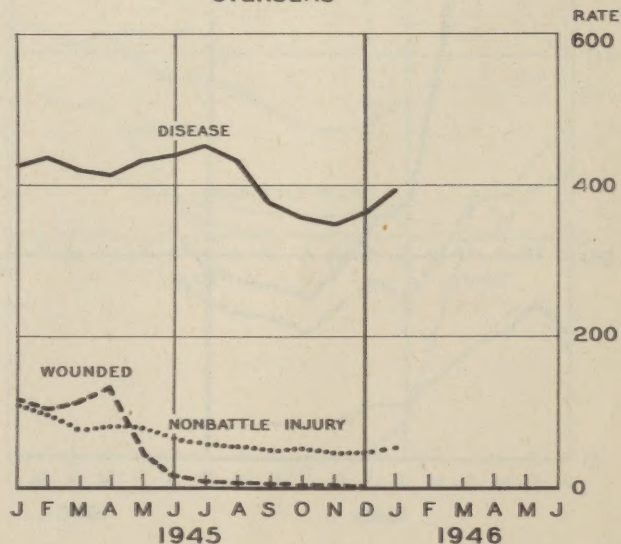


#### MAJOR CAUSES

##### CONTINENTAL UNITED STATES



##### OVERSEAS



\* Middle and Western Pacific.



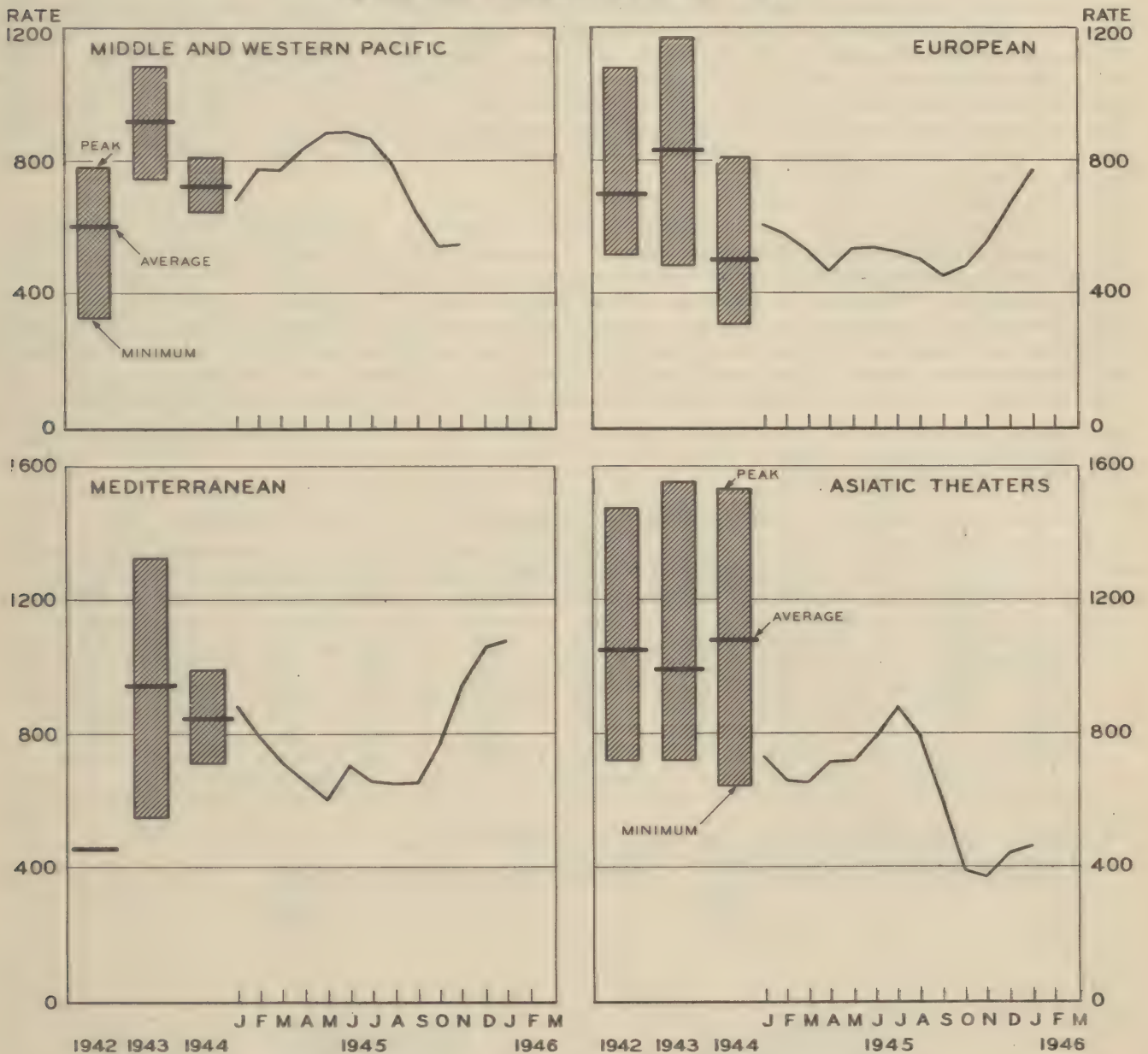
# DISEASE AND INJURY

## DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

Medical reports for the European Theater reveal a further advance in disease admissions for January, the rate having moved from 664 in December to 773 in January. Increases in respiratory and venereal disease admissions account for about half of the rise. In the Mediterranean there was little change, an improvement in venereal disease incidence being more than offset by a seasonal increase in respiratory disease. There was a slight rise in the admission rates for troops in the Asiatic theaters, almost wholly the result of increased venereal infection. In the Pacific the current picture is not known, but it would be expected that December and January rates would exceed that for November shown below. See page 7 for a discussion of admission rates in the occupied areas.

## DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

RATES PER THOUSAND MEN PER YEAR





# DISEASE AND INJURY

## RESPIRATORY DISEASE OVERSEAS

The most recent admission rates for troops overseas suggest a very favorable respiratory season in all theaters. Seasonal increases have occurred, but on a scale far below those of previous years. The table below compares the most recent rates for all respiratory diseases (including pneumonia) with the peak rates for previous seasons. The months in which the peak rates occurred are also shown in order to evaluate the likelihood that the most recently reported months are those of maximum or near-maximum incidence this winter. The Pacific is omitted from the table because the latest month reported, November, is almost certainly not the month of highest incidence for the 1945-1946 season. Moreover this season will be far different from previous ones in the Pacific because of the deployment of troops in more northern latitudes.

Except for the Asiatic theaters, in each instance shown in the table the latest rate is for a month during which at least two of the three previous peak respiratory rates were noted in past years. However, preliminary reports from Europe for the first three weeks of February yield a rate of 160 for this period with a peak during the week ending 1 February. The incidence of respiratory disease has varied widely throughout the theater. The highest rates have been reported for the comparatively small force in the Berlin area where the rate was in excess of 350 per thousand men per year for the first week of February. High rates are also being reported rather consistently for troops of the Bremen Port Command, which is small, and for the Third Army.

Particular interest attaches to the incidence of respiratory disease among U. S. Army troops in the United Kingdom because a mild epidemic of influenza B occurred there following the outbreak in the U. S. Mortality data suggest that the peak civilian incidence was reached early in February, two months later than in the U. S. It is noteworthy, therefore, that rates for common respiratory disease and influenza among assigned and casual Army troops in the London area were never in excess of 76 during the first seven weeks of 1946 although the average theater rate increased steadily during this interval and was never less than 100. The failure of the rate for Army troops in the U. K. to rise appreciably in the face of an influenza epidemic in the civilian population cannot be taken as evidence of the efficacy of the influenza vaccine without considerable further study, for the force is rather small and geographically concentrated.

PEAK RESPIRATORY DISEASE\* ADMISSIONS PER 1,000 MEN PER YEAR

Theater	1945-46**		1944-45		1943-44		1942-43	
	Rate	Month	Rate	Month	Rate	Month	Rate	Month
European	140	Jan	179	Jan	713	Nov	719	Jan
Mediterranean	163	Jan	208	Jan	303	Jan	227	Jan
Asiatic Theaters	97	Jan	149	Dec	226	Jan	214	Dec
Africa - Middle East	106	Dec	210	Dec	393	Feb	281	Dec
Alaskan	67	Jan	137	Feb	362	Jan	412	Jan
United States	207	Feb	207	Feb	566	Dec	527	Jan

\* Common respiratory disease, influenza, and pneumonia.

\*\* Latest reported month and peak to date.



# DISEASE AND INJURY

## HEALTH CONDITIONS IN U.S. ARMIES OF OCCUPATION

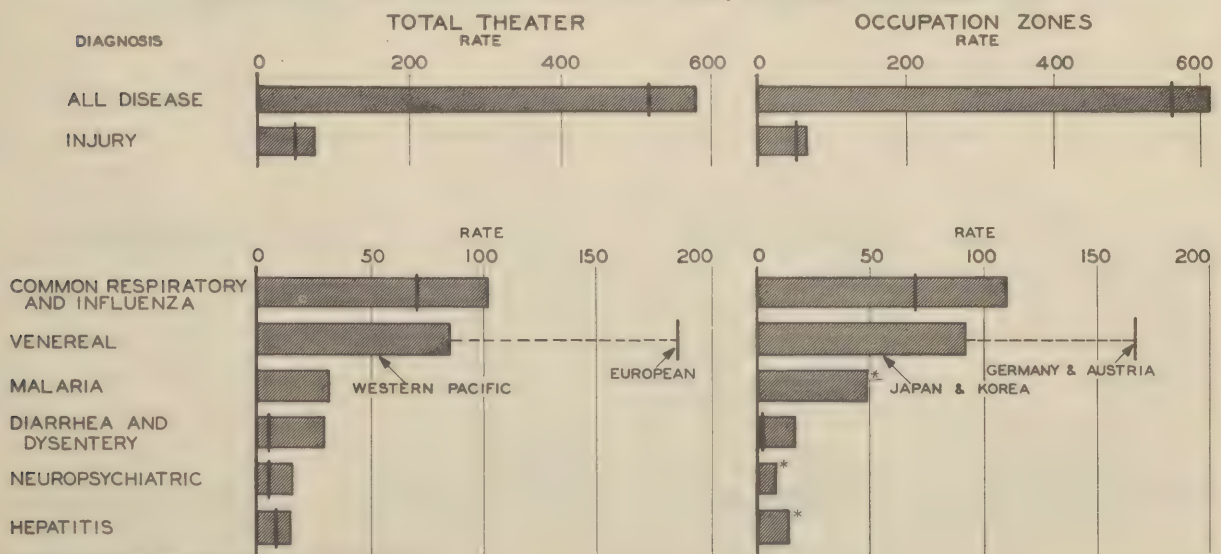
Information on the health of troops in the Western Pacific is slow in arriving, November being the latest month for which complete information is available, but all indications are that the morbidity experience thusfar has been comparatively favorable there as in Europe. The only outstanding exception of statistical importance is venereal disease, admission rates for which are highest in Europe but are rising with especial rapidity in Japan. The accompanying panels compare admission rates in the two areas, at the theater level and for the occupation zones themselves. Full detail on troops in Germany and Austria is not available. For both areas the rates pertain to October and November of 1945.

The general level of morbidity was approximately the same in both areas, but troops in the occupation zones had somewhat higher rates. The outstanding differences between the two theaters consist in the much higher venereal disease rates in Europe and the greater incidence of respiratory disease, malaria, and diarrheal disease in the Pacific during this period. Since there is no evidence that the maximum level of venereal infection had been reached in Japan by November, this differential may well be short-lived. Similarly, in the case of common respiratory disease and influenza there was a sharp upswing in Europe in December which brought the rate to the level of the Pacific in November, and a further increase to 135 in January. Even these higher rates are quite favorable, however, for the winter season in these areas.

Parallel differentials pertain to the admission rates of troops in the occupation zones themselves, although full details on troops in Germany and Austria are lacking. Also worthy of mention are the far higher incidence of scabies and diphtheria in Europe and the smallpox outbreak in Japan and Korea. A teletype conversation on 8 March established that 88 cases of smallpox had occurred in U. S. occupation forces. All troops have now been re-vaccinated against smallpox and an extensive immunization program is under way among civilians. Early in March civilian incidence in Japan was about seven per 1,000 per year. During the war period the production of smallpox vaccine lapsed in Japan and not until January 1946 was civilian production re-established. By April, it has been estimated, 50 million civilians will have been vaccinated in Japan.

In general the admission rates for occupation troops are closely similar to those for the rest of the troops in the theater. However, troops in Japan and Korea had a somewhat higher malaria rate (from relapses), while diarrheal disease was more than twice as prevalent in the Philippines as in the occupied zone. Venereal disease admissions were 92 per 1,000 men per year in Japan and Korea during October and November, and only 80 elsewhere in the Western Pacific. The neuropsychiatric admission rate was eight for troops in Japan and Korea and 18 for those in the rest of the command, but even the latter rate is phenomenally low. Important changes in morbidity levels in Japan during November were confined to the rise in venereal disease from 64 to 117, and in malaria from 34 to 59. The latter followed discontinuance of routine atabrine suppression (see page 10, this issue).

HEALTH OF U.S. TROOPS IN OCCUPATION ZONES IN EUROPE AND THE PACIFIC  
ADMISSIONS PER THOUSAND MEN PER YEAR, OCTOBER-NOVEMBER 1945





# DISEASE AND INJURY

## SPECIAL DISEASE HAZARDS IN BASIC TRAINING CENTERS

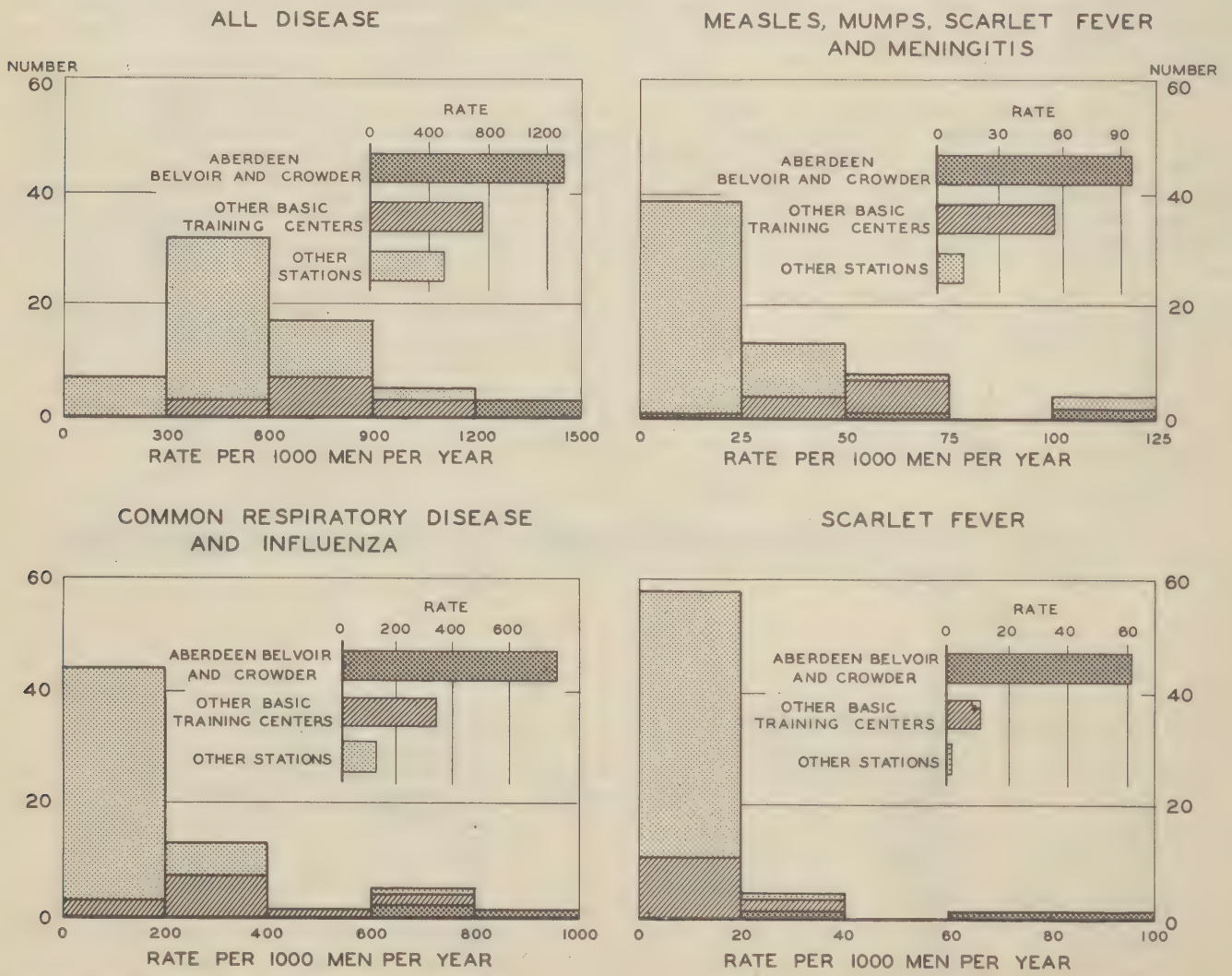
It has long been recognized that "raw" recruits constitute the most fertile soil for epidemics of the diseases transmitted by discharges of the respiratory tract. Unfortunately, there are few specific control measures applicable to this group of diseases. Two such measures are: (1) the prophylactic use of sulfadiazine for the prevention of meningococcal meningitis; and (2) vaccination against influenza. Against most of the other diseases of this group reliance must be placed on physical inspections, early detection and hospitalization of cases, and such other general hygienic measures as avoidance of overcrowding. It is fortunate that mobilization for World War II led to no major epidemic of these diseases.

During the current respiratory season the incidence of streptococcal respiratory diseases, notably scarlet fever, has increased to a point where it gives rise to some concern for the health of men sent to certain camps for basic training. Streptococcal infections are particularly important because of their occasional severity, the incidence of complications, and the fact that they are followed by rheumatic fever in some instances. There is also the potential danger that many cases of serious streptococcal pneumonia would occur if an epidemic of influenza were to develop at a post where streptococcal infections were prevalent.

It is undoubtedly true that stations where the training of new men is an important activity have had higher than average rates throughout the war, especially during the winter and early spring months. However, at the present time it is believed that morbidity at several stations has reached a point where consideration should be given to administrative measures to deal with a situation of potential danger.

The extent to which admissions to hospital and quarters in basic training centers

### STATIONS WITH ADMISSION RATES OF SPECIFIED SIZE,\* FEBRUARY 1946



\* Having 5,000 or more strength each week in February.



# DISEASE AND INJURY

## SPECIAL DISEASE HAZARDS IN BASIC TRAINING CENTERS (Continued)

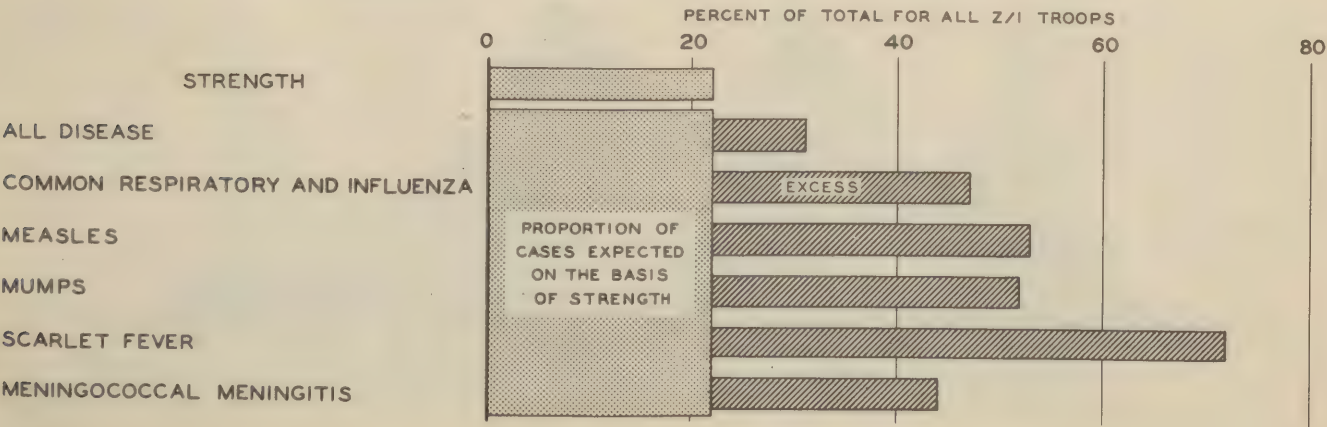
deviate from the average pattern of all other stations is revealed by the chart on page 8 for stations having 5,000 or more strength each week in February. The vertical bars give the number of stations whose rates fall between the limits shown on the horizontal scale. The shaded areas represent the sixteen AAF, ASF, and AGF basic training centers active during February. Plainly the training centers not only have higher rates in general but also account for most of the extremely high rates reported by large stations during the month. The three basic training centers having the highest admission rates for all disease were: Camp Crowder, Missouri; Aberdeen Proving Ground, Maryland; and Fort Belvoir, Virginia. These are shown with very dark shading. An inset in each panel gives the average rates for these three centers, for all other basic training centers, and for all other large stations during February. The rates for the three stations tend to be extreme for the individual diagnoses as well as for all disease. For scarlet fever, for example, there were six stations with rates above 20 per 1,000 men per year, five of which were basic training centers. Belvoir had the highest rate, 84 per thousand men per year, while Crowder was second with 74, and Aberdeen fifth with 26. The average rate for all troops in the Z/I was 6.3, while the 64 stations with strength above 5,000 had an average rate of 7.2 per 1,000 per year. For the 16 replacement training centers the incidence averaged 21 in contrast to only two for the other 48 large stations. The average rate for Camp Crowder, Fort Belvoir, and the Aberdeen Proving Ground was 61 per 1,000 men per year.

The findings are summarized further in the chart below, which portrays the proportionate contribution of the 16 basic training centers to the aggregate morbidity in the Z/I during February. Thus, with only 22 percent of the strength, they contributed 31 percent of all disease admissions, 47 percent of the cases of common respiratory disease and influenza, 53 percent of the measles, 52 percent of the mumps, 44 percent of the meningococcal meningitis, and 72 percent of the scarlet fever. The three most extreme stations, Crowder, Aberdeen, and Belvoir, had 15 percent of all common respiratory disease and influenza, and 37 percent of all the scarlet fever in the U. S. during February although they had but 3.6 percent of the strength.

The importance of the training function, with its selection of susceptible men, and its impetus to rapid turnover and continual exposure of men to new disease hazards, is illustrated by the finding that morbidity varies directly with the percentage of trainees at the 16 basic training centers. This is not true, for example, of the separation centers. Few of the 16 basic training centers have other important activities, e.g. induction, reception, and separation, which might help to elevate their admission rates, and these are not the stations with the highest rates.

Training activities are not seriously threatened by the unusually high morbidity at a small number of basic training stations. However, all practicable steps should be taken to improve the situation. Recommendations which have been made include: 1. Limitation, so far as feasible, of the rapid and continual introduction of susceptibles into large basic training organizations, especially during the respiratory disease season; 2. Temporary curtailment of the assignment of new recruits to posts where epidemics of the respiratory diseases are in progress; and 3. Elimination of overcrowding and adherence at all times to a minimum standard of at least 60 square feet per man in barracks housing trainees.

### PROPORTIONATE CONTRIBUTION OF ALL SIXTEEN BASIC TRAINING CENTERS TO MORBIDITY IN THE Z/I DURING FEBRUARY





# DISEASE AND INJURY

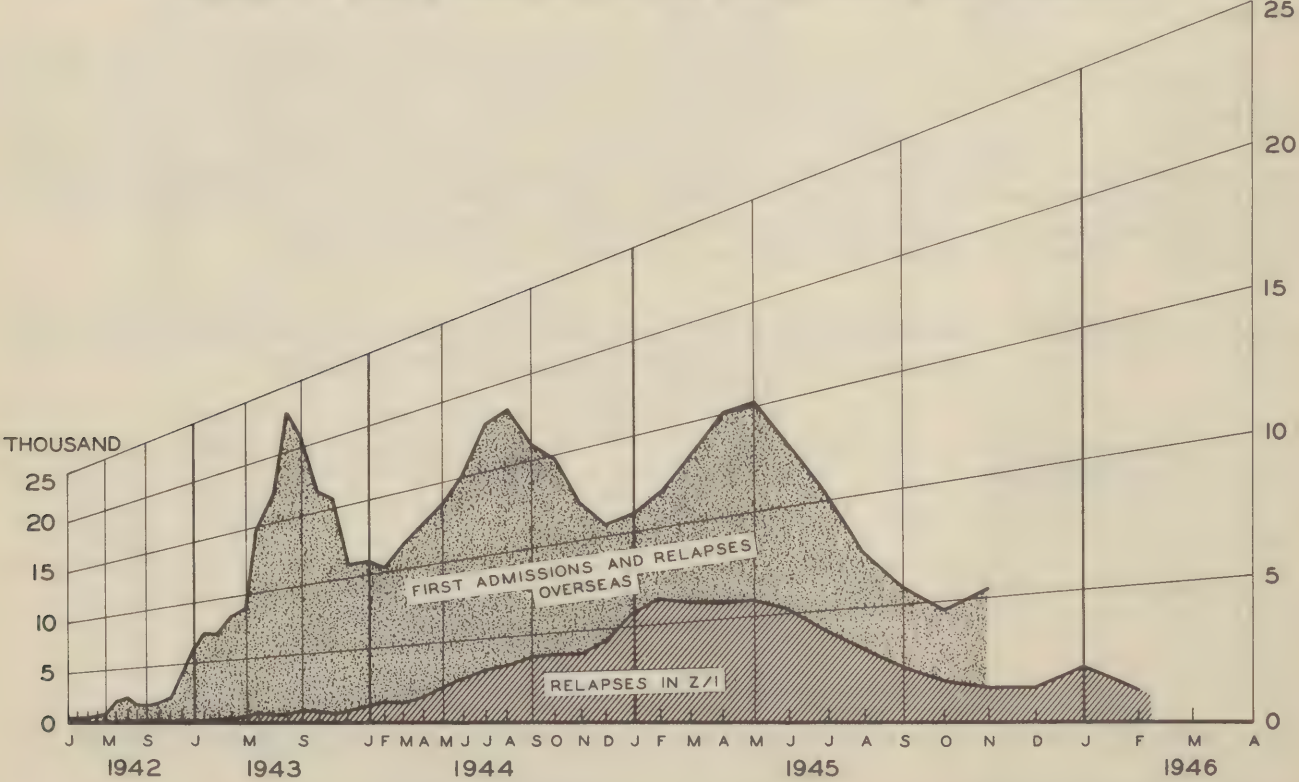
## CURRENT STATUS OF MALARIA PROBLEM

The tremendous inroads upon effective manpower which malaria made during the war years are now a thing of the past. Peace-time conditions will permit anti-mosquito control of sufficient extent to hold transmission to a small fraction of previous levels. The admissions which occur now are largely relapses of infections previously acquired. They increased somewhat in November following the discontinuance of routine atabrine suppression in the Pacific. Although large numbers of relapses have occurred in the Z/I among troops returned from overseas, their number failed to reach the high levels previously forecast in HEALTH. Moreover, although the fear was widespread among civil health authorities that so many returning veterans would be malaria carriers that epidemics would occur in the civilian population, none has occurred, partly, perhaps, because of preventive measures discussed below.

The latest admission rates for malaria are below ten per 1,000 men per year in all major commands except the Western Pacific and the two Asiatic theaters. In the Western Pacific, where routine use of atabrine suppression was discontinued on 1 November, the rate advanced from 24 in October to 35 in November. Atabrine suppression is strictly an emergency measure, and has the marked disadvantage of denying to admission rates their value as indicators of malaria transmission. Its discontinuance will permit much closer supervision of malaria transmission which can be so effectively controlled by anti-mosquito measures under garrison conditions. It will also obviate the minor disadvantages of atabrine suppression which during the combat period were accepted as a small price to pay for the retention on active duty of thousands of soldiers infected with malaria. Now, however, it should be possible to reduce the chance of infection to such a low point that even a small number of men deleteriously affected by atabrine would constitute an unnecessarily high cost to pay for the small improvement which could be made in the malaria admission rate by routine use of atabrine. The most serious of the side-effects of atabrine concerns a skin disease, atypical lichen planus, which may occur in a very small percentage of men taking atabrine and which may cause prolonged disability. The great impetus given to malaria research during the war resulted in the development of promising compounds for both the suppression and the treatment of malaria, compounds which do not color the skin or produce the unpleasant even if transient intestinal disturbances often noted by persons taking atabrine. Although their complete harmlessness has yet to be proved by more prolonged and widespread clinical use, the outlook is excellent for developing compounds superior to atabrine for military use.

## TREND OF MALARIA INCIDENCE IN THE U.S. ARMY DURING THE WAR PERIOD

NUMBER OF CASES DIAGNOSED IN THE UNITED STATES AND OVERSEAS THOUSAND





# DISEASE AND INJURY

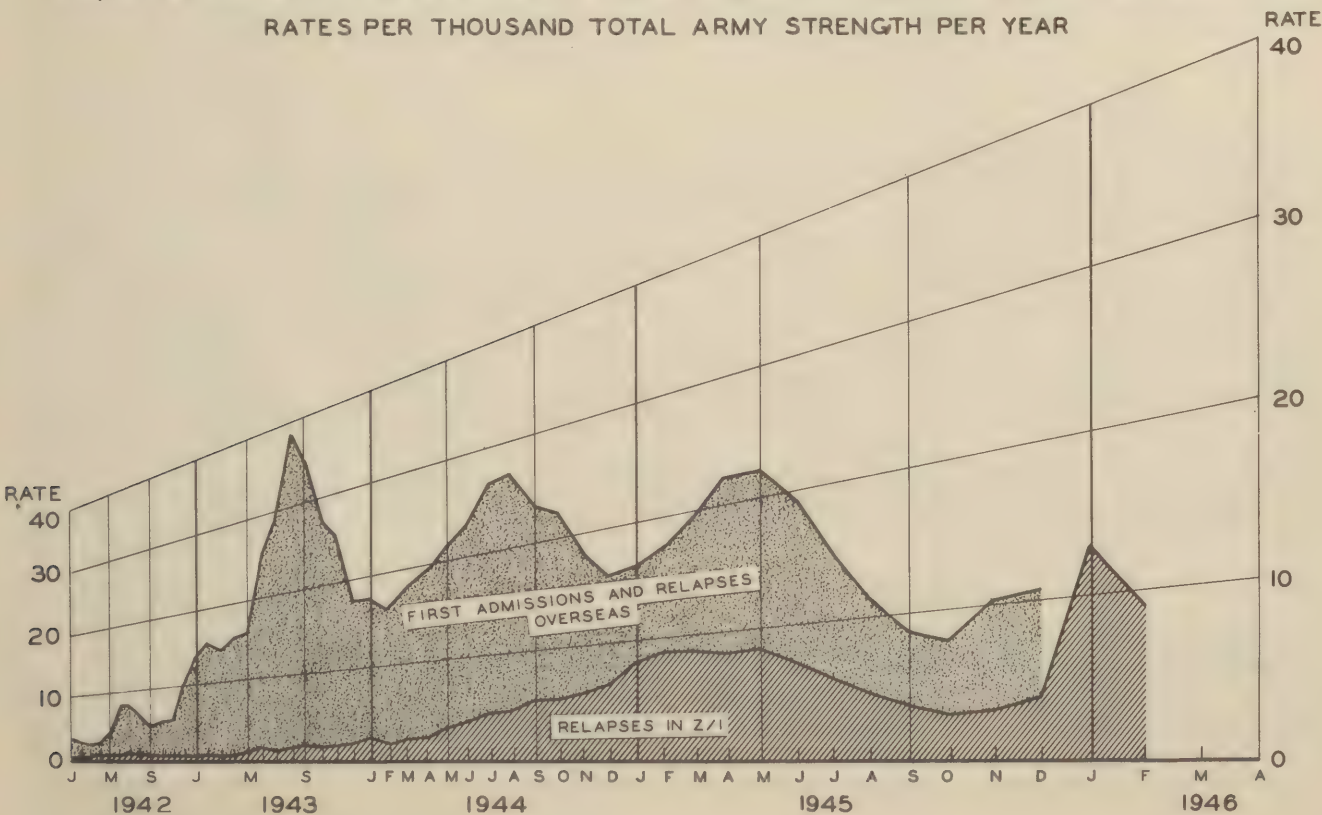
## CURRENT STATUS OF MALARIA PROBLEM (Continued)

The chart on the opposite page gives the number of malaria admissions monthly from 1942 through 1945 and early 1946, while the comparable rates for the Army as a whole appear below. Although the peak incidence occurred in August 1943 with about 21,000 admissions, even as late as 1945 there were months in which as many as 15,000 admissions were reported in the Army as a whole, and only after V-J Day did the total Army rate fall below 10 per 1,000 per year. How much of the decline in Z/I admissions reflects speedy separation from the Army cannot be estimated accurately but it is surely large. One point of interest is that the Veterans Administration reports having treated 2,300 malaria cases in the period April-June 1945, when Army admissions in the Z/I were about 16,000. Both charts are drawn in historical perspective which places greater emphasis upon more recent experience.

The U. S. Public Health Service early made provision for mobile teams which would move into areas threatened by malaria epidemics set in motion by the return of infected personnel from overseas. Three factors have operated to reduce the risk far below the predicted level: (1) mosquito control measures in the Z/I minimized the chance that mosquitoes might feed on infected returnees; (2) in the absence of reinfection, relapsing malaria will die out within a period of two to three years in a great majority of cases; and (3) long-continued use (18 months or more) of atabrine in suppressive doses apparently greatly lessens the chance of later clinical activity unless re-infection occurs. Continuation of suppressive medication for four weeks after arrival in the Z/I, the excellent mosquito-control carried out by the U. S. Public Health Service in the mile-wide zone outside the boundary of Z/I military camps, and careful screening of hospital patients, have all operated to reduce the chance of civilian epidemics originating with infected Army personnel. So many men with a history of malaria have been separated from the Army that some increase in civilian incidence will undoubtedly appear in statistics for 1945 and 1946 from these soldiers alone. For the first nine months of 1945 U. S. Public Health Service reports, admittedly incomplete but useful in determining trend, reveal an incidence which is not greatly different from the average level of pre-war years. Only an insignificant number of civilian cases has been traced to infected veterans.

The war greatly accelerated research in malaria and advanced knowledge of its prevention and treatment. Never again should the disease prove so costly to U. S. armies in the field. During the war atabrine was invaluable in keeping men on duty although it did not prevent transmission. Even today transmission can be prevented only by sound anti-mosquito measures which in peace-time must be the main reliance of a malaria control program.

TREND OF MALARIA INCIDENCE IN THE U.S. ARMY DURING THE WAR PERIOD  
RATES PER THOUSAND TOTAL ARMY STRENGTH PER YEAR



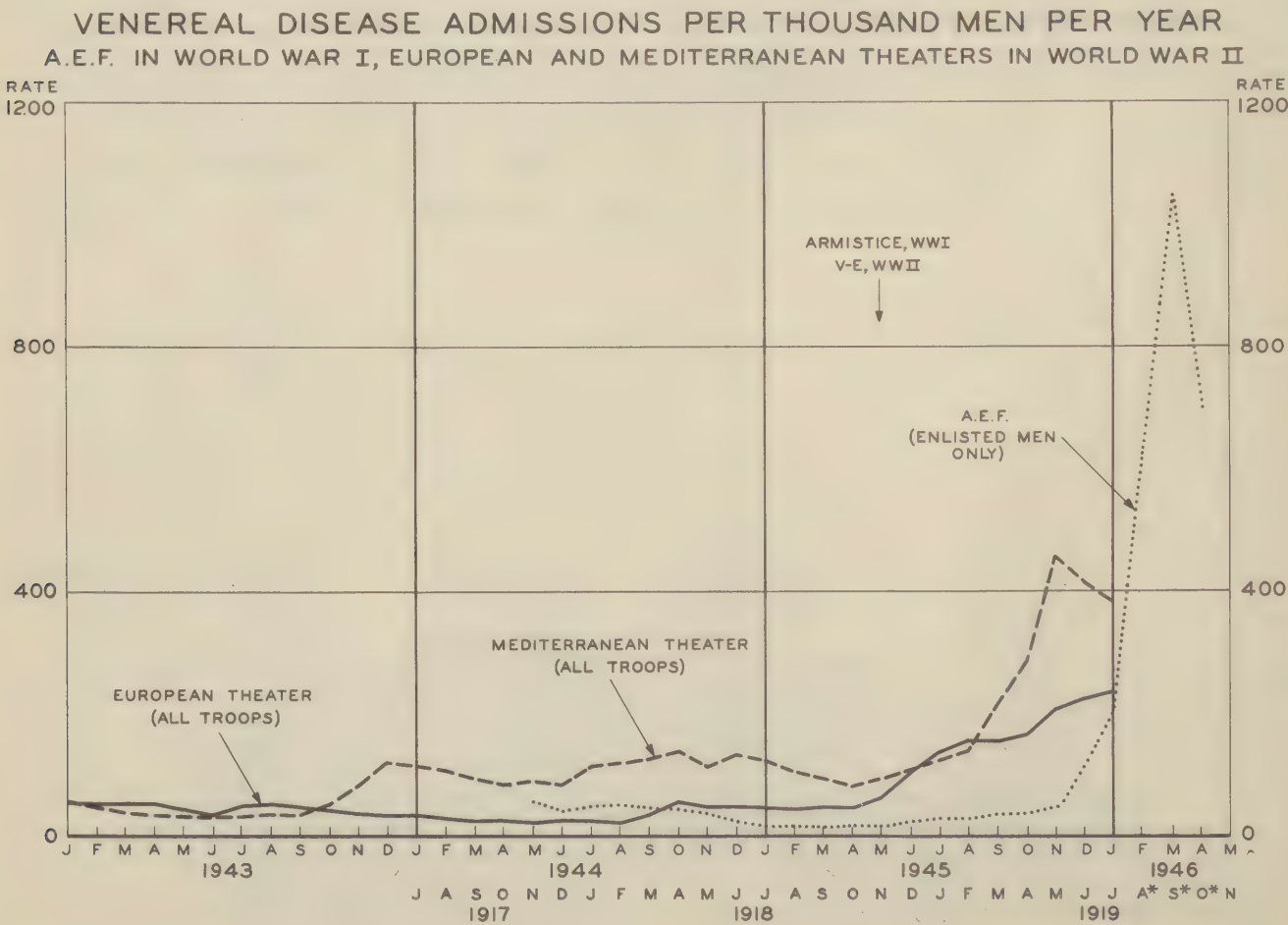


# DISEASE AND INJURY

## VENEREAL DISEASE OVERSEAS

The latest available reports indicate that further increases have occurred in the incidence of venereal disease in all theaters except the Africa-Middle East and Mediterranean. In the Western Pacific admissions increased in November to 91 per thousand strength after a four-month recession from the previous peak of 97 in June. This rise is largely the result of the increasing incidence among troops in Japan coupled with their numerical importance. During November troops in Japan had a rate of 117 per thousand men per year. In the Latin American area the January rate is 58, the highest rate reported since May 1943. In the past three months the incidence in Latin America has risen to twice the average for the first ten months of 1945. Similarly, the Asiatic theaters reported an admission rate of 101 for January, the incidence having risen sharply from 55 in November and 81 in December to reach the maximum level reported for troops in this area since the war began. In Europe, too, the most recent rates are excessive. The January rate of 233 is almost six times the level in effect prior to V-E day. However, the December rate of 417 for the Mediterranean area is 39 points lower than the November rate and represents the first decrease since April 1945. In January the incidence in the Mediterranean declined further, the rate for all personnel being 382 per thousand men per year. The decline is confined to the rate for white troops. The rate for Negro troops, now quite small in number, increased to 2,250 in January, about 12 times the rate for white troops in this theater. In the Alaskan Department the rate for January rose to 17 per thousand men per year, the highest since January 1942, but still very low in relation to other areas where exposure is greater.

In the panel below, the rates for troops in the European and Mediterranean Theaters during World War II are compared with those for enlisted men of the A.E.F. in France and Germany during the first war and the occupation period. The series for the two wars have been equated around May 1945 and November 1918. The phenomenally low rates for the A.E.F. in the latter part of 1918 are generally considered to be unreliable in that reporting was incomplete according to present-day criteria. The increase in venereal disease in the A.E.F. after the Armistice developed more slowly than that which set in after V-E Day among troops in the European theaters. However, ten months after the Armistice it reached a peak of 1,047 per 1,000 strength. At this time the average strength was only 32,000.





# DISEASE AND INJURY

## HEALTH BRIEFS

### Diarrheal Disease

Admission rates for diarrhea and dysentery among troops in the Z/I are currently lower than at any time since early 1942, although some part of the low rate may be attributable to non-reporting on the part of men on pass or furlough. Relatively favorable rates also prevail in most overseas areas, although there are important exceptions. In the Latin American area admission rates have fluctuated markedly since June 1945. In the Asiatic theaters, the admission rates are lower than at any time during the war, but are considerably higher than those of any other theater. The latest reported rates are tabled below, and compared with the average rates for the war period. The reduction is a rough measure of the improvement in sanitation following the cessation of hostilities. It is interesting to note that the ranking of the theaters with respect to their latest rates bears a close relationship to that for average rates through the war-period. However, current rates are only approximate measures of the environmental hazards which troops face in the various areas, for they may be subject to further reduction by appropriate command action.

DIARRHEA AND DYSENTERY ADMISSIONS PER 1,000 MEN PER YEAR

Command	Latest	Reported	Average for War Period*
	Month	Rate	
United States	January	4	9
Asiatic	December	50	143
Africa-Middle East	December	34	132
Western Pacific	November	25	75
Latin American	January	10	20
Mediterranean	December	7	71
European	January	3	14
Middle Pacific	December	1	31
Alaskan	December	0	5

\* January 1942 - August 1945

### Physical Standards for Induction

The notion is prevalent that current physical criteria for induction are far less stringent than during the period of active hostilities. This is not the case, however, as the standards set in the April 1944 revision of MR 1-9 are substantially those in effect at the present time. Departure from the standards published then are not only very few but are chiefly in the direction of more stringent requirements, as certain of the defects formerly allowable for limited service are now altogether disqualifying.

### Diphtheria in Europe

The Army admission rate for diphtheria in the European Theater advanced from 2.8 per 1,000 per year in December to 4.5 in January 1946. For the week ending 1 February 94 admissions and 2 deaths were reported, and the rate of 9.7 is the highest yet reached in the theater. Most of the cases originated in different units and no epidemic pattern is evident. This rise has occurred after the institution of a program of immunizing hospital personnel and others whose duties bring them into close contact with civilians. It would appear that the immunization program has not yet been in operation for a sufficiently long period to affect the incidence of the disease, or that it is not yet sufficiently general to accomplish this result. It is of interest that a marked increase in diphtheria admissions also occurred among U. S. Army troops in Europe during 1919.

Some seasonal decline in the incidence of diphtheria among German civilians occurred in January. A widespread program of immunization is in progress in the German civilian population.

### Tuberculosis in the Z/I

Medical examinations at separation stations continue to maintain the reported incidence of tuberculosis at an artificially high level, as reported in HEALTH for January. However, the provisional February rate of 3.9 is well below the peak of 4.7 reached in January, and apparently reflects the proportionately smaller number of separations effected during February. Corrected rates, free from the bias introduced by rapid screening, are not yet available.



HOSPITALIZATION

HOSPITALIZATION OVERSEAS

During January T/O capacity (fixed plus operating nonfixed) of hospitals present in all overseas theaters declined from 129,000 to 73,000 beds, and at the end of the month the capacity present was 41 percent above the aggregate War Department authorization. During this transition period the T/O bed capacity of units present in overseas theaters as reported in the War Department Troop List means little because only skeleton staffs remain in some units and also because units are dropped from the Troop List as soon as inactivation orders are issued which in many instances occurs before actual inactivation. A more meaningful index is operating bed capacity which declined from 95,000 to 73,000 during January. Similarly, the patient load fell from 33,000 to 29,000 during the month.

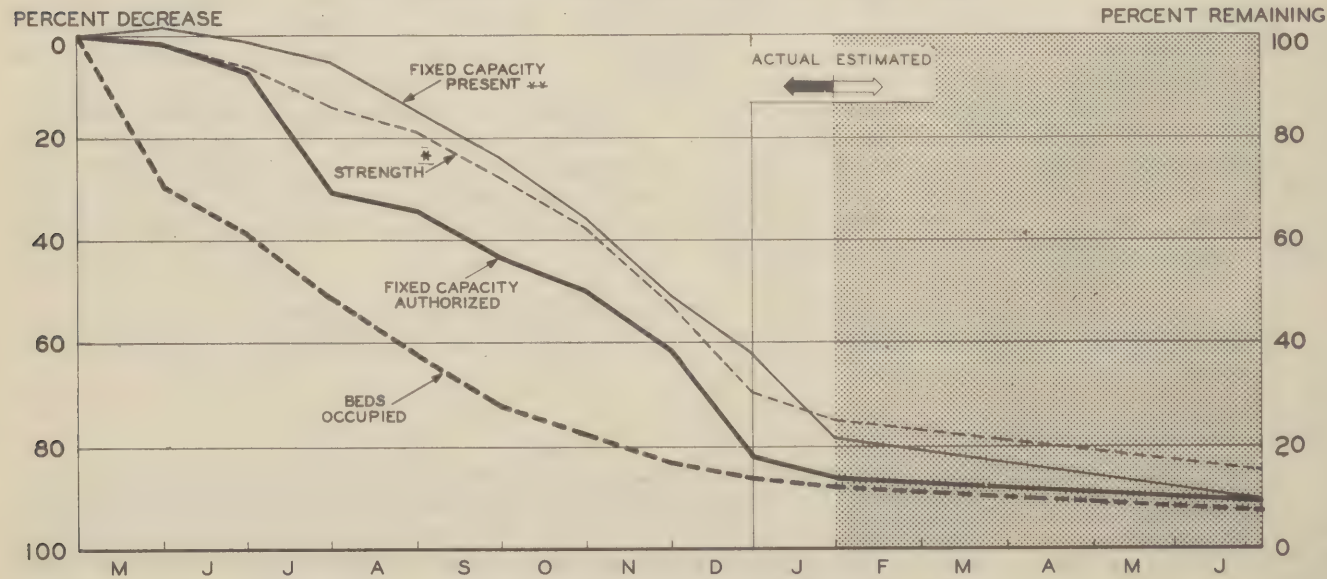
Chief importance attaches to the speed with which medical facilities are being adjusted to reduced requirements overseas, shown graphically below for all theaters combined. Between 30 April 1945 and 31 January 1946 the T/O capacity of fixed units (and of operating nonfixed units after 30 November 1945) overseas declined by 78 percent. The comparable percentage declines for personnel are somewhat lower, 76 percent for Medical Corps officers and 75 percent for all Army strength overseas. The percentage for doctors would be somewhat higher if it were possible to exclude those enroute to the Z/I, as is done in the case of all overseas strength. By 30 June the strength should have fallen to 840,000 according to present strength forecasts. As may be seen from the table below this will mean a reduction of about 4,567,000 below the 30 April level in the number of men for whom hospitalization must be provided. By 31 January 89 percent of this reduction had already been accomplished. By the

COMPARATIVE REDUCTION IN STRENGTH; BEDS AUTHORIZED, BED CAPACITY, AND BEDS OCCUPIED IN ALL OVERSEAS THEATERS

	Strength a/ (in Thousands)	Thousands of Beds		
		Authorized	Present b/	Occupied
Base Date 30 April 1945	5,407	361.8	338.5	226.5
Report Date 31 January 1946	1,328	52.0	73.4	28.8
Forecast for 30 June 1946	840	32.9	32.9	16.0
Reduction Required to Meet Forecast	4,567	328.9	305.6	210.5
Reduction Accomplished by 31 January				
Number	4,079	309.8	265.1	197.7
Percent of Required Reduction	89.3	94.2	86.7	93.9

a/ Overseas strength for which hospitalization must be provided.  
 b/ Includes operating nonfixed beds after 30 November 1945.

DECREASE IN STRENGTH AND BEDS PRESENT, AUTHORIZED AND OCCUPIED IN OVERSEAS THEATERS SINCE 30 APRIL 1945



\* Strength subject to authorization. \*\* Includes operating nonfixed capacity after 30 November 1945.



# HOSPITALIZATION

RESTRICTED

## HOSPITALIZATION OVERSEAS (Continued)

same process it may be determined that 87 percent of the required decline in T/O capacity present, 94 percent of the required reduction in authorized beds, and 94 percent of the expected fall in the hospital patient census had already occurred by 31 January.

The tables below continue the series previously shown in HEALTH although such factors as abrupt changes in strength and the presence of incompletely staffed hospitals on the one hand, and on the other the dropping of units from the Troop List upon publication of inactivation orders, combine to rob the figures of some of their meaning. For the European and Pacific theaters operating nonfixed beds have been added to the fixed T/O capacity of units reported in the Troop List since War Department authorizations now cover all fixed units and professionally staffed nonfixed units. The significance of the lag between publication of an inactivation order and inactivation of the unit is illustrated by the fact that theater counts of beds present now greatly exceed those obtained from the Troop List. For example, the Troop List for 1 February yields a count of 35,500 fixed and nonfixed T/O beds present in the European Theater while the theater itself reported 50,750 T/O beds for that date. This also explains why theater counts of operating beds are in some instances above Troop List totals. In all theaters except the Asiatic, operating bed capacity exceeded authorized levels at the end of January, but in none of the major theaters was the patient census above 52 percent of operating capacity. In general, however, the occupancy percentages for 31 January were slightly in excess of those for 31 December. The recent changes are shown below in percentage form

### BEDS AVAILABLE AND OCCUPIED IN OVERSEAS THEATERS a/ Number of Beds, 31 January 1946

Theater	W. D. Author- ization	T/O Fixed And Operating Nonfixed Present <u>c/</u>	Operating		Occupied <u>d/</u>
			Number <u>d/</u>	Percent Of Beds Authorized	
ALL THEATERS	51,994	73,427	72,993	140.4	28,754
American <u>b/</u>	1,746	3,225	3,345	191.6	737
European	22,404	29,877 <u>e/</u>	27,658 <u>e/</u>	123.5	13,273 <u>g/</u>
Mediterranean	1,930	3,550	3,400	176.2	1,269
Pacific	23,537	33,225 <u>f/</u>	36,925 <u>f/</u>	156.9	12,797 <u>h/</u>
Asiatic	1,965	3,050	1,155	58.8	597
Africa-Middle East	412	500	510	123.8	81

### Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) <u>i/</u>	W. D. Author- ization	Bed Capacity		Beds Occupied as	
			Number Present	Operat- ing	Percent of Strength	Percent of Operating
ALL THEATERS	1,328	3.9	5.5	5.5	2.2	39.4
American <u>b/</u>	58	3.0	5.5	5.7	1.3	22.0
European	560	4.0	5.3	4.9	2.4	48.0
Mediterranean	48	4.0	7.4	7.0	2.6	37.3
Pacific	588 <u>j/</u>	4.0	5.6	6.3	2.2	34.7
Asiatic	62	3.2 <u>k/</u>	4.9	1.9	1.0	51.7
Africa-Middle East	10	4.0	4.9	4.9	0.8	15.9

- a/ In fixed and operating nonfixed type hospital units. Only the European and Pacific theaters have hospital units of the nonfixed type.
- b/ Includes Alaskan Department and excludes North Atlantic bases and South Atlantic.
- c/ T/O fixed present reported in W. D. Troop List dated 1 February 1946. Operating nonfixed reported by theaters telegraphically for 1 February 1946.
- d/ Reported by theaters telegraphically, Mediterranean for 26 January, all other theaters 1 February.
- e/ Includes 4,577 operating beds in hospitals of nonfixed type..
- f/ Includes 2,800 operating beds in nonfixed hospitals in WESPAC.
- g/ Includes 1,668 beds occupied in nonfixed hospitals.
- h/ Includes 636 beds occupied in nonfixed hospitals in WESPAC.
- i/ Includes only strength within geographic limits of theaters. Personnel enroute to or from the theaters are excluded.
- j/ Includes 6,000 Philippine Scouts. U. S. Army is committed to provide hospitalization for up to 50,000 of these personnel by 30 June 1946.
- k/ Joint authorization. The percentage is 4.0 for troops in China, and 3.0 for those in India-Burma.

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# HOSPITALIZATION

## HOSPITALIZATION OVERSEAS (Continued)

for the major overseas theaters. The line for T/O capacity present has been dropped for recent months and operating capacity substituted as the better index of facilities available.

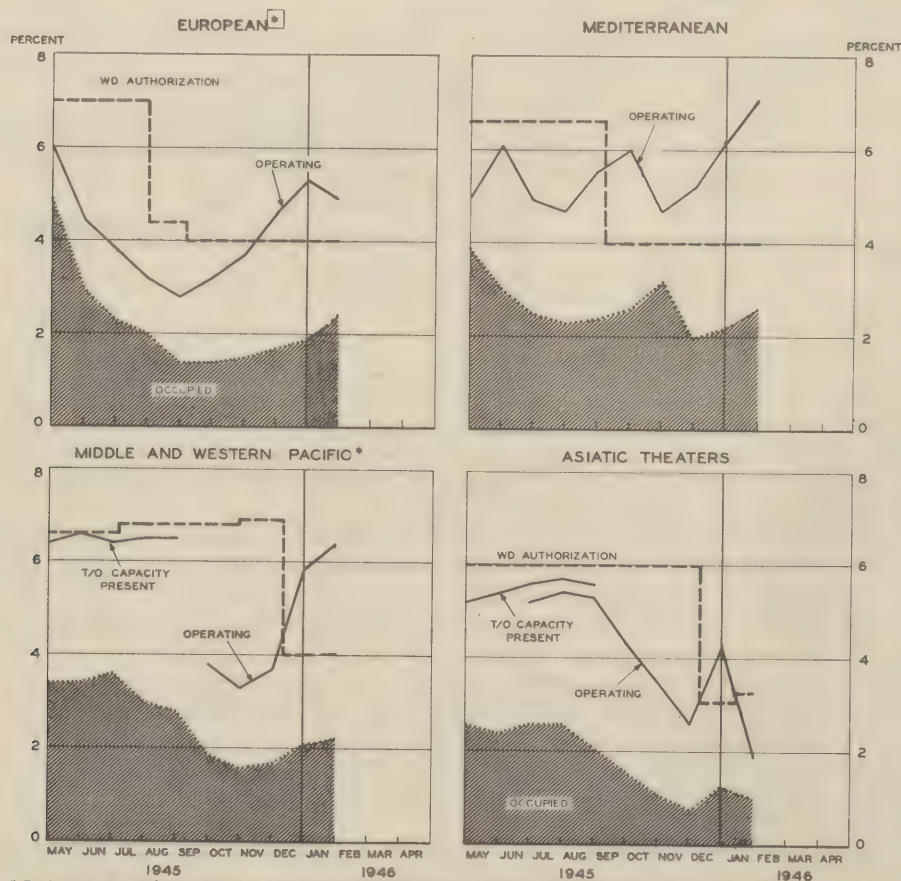
Of the 247,000 beds in field, station and general hospitals, and in convalescent centers and camps in Europe, the Mediterranean, and the Africa-Middle East on 30 April 1945, 65 percent had been returned to the Z/I by 10 March 1946 and an additional 16 percent had been or were to be inactivated overseas. In the Pacific and Asiatic theaters 54 percent of the beds present on 31 August had been inactivated overseas by 10 March; 11 percent were scheduled for inactivation on this date; and only six percent had been disposed of by return to the Z/I. The table below summarizes the disposition of beds in these major areas.

DISPOSITION OF HOSPITAL FACILITIES OVERSEAS BY 10 MARCH 1946\*

Disposition	Number of Beds	
	Europe, Mediterranean Africa - Middle East	Pacific and Asiatic Theaters
In Theater on Base Date	247,000 on 30 Apr 45	118,000 on 31 Aug 45
Returned to Z/I by 10 March 1946		
Total	160,000	6,500
Percent Inactivated		
in Z/I by 10 March	93.1	100.0
Percent To Be Retained		
or Inactivated in the Z/I	6.9	-
Inactivated in Theater	31,400	63,400
To Be Inactivated in Theater	7,000	12,650
Total in Theater To Be Retained or Inactivated	48,600	35,450

\* Including general, station, and field hospitals and convalescent centers and camps.

FIXED HOSPITALIZATION IN OVERSEAS THEATERS  
BEDS AS PERCENT OF STRENGTH



\* Professionally staffed nonfixed hospitals included in European beginning 30 November and in Middle and Western Pacific beginning 31 December.



# HOSPITALIZATION

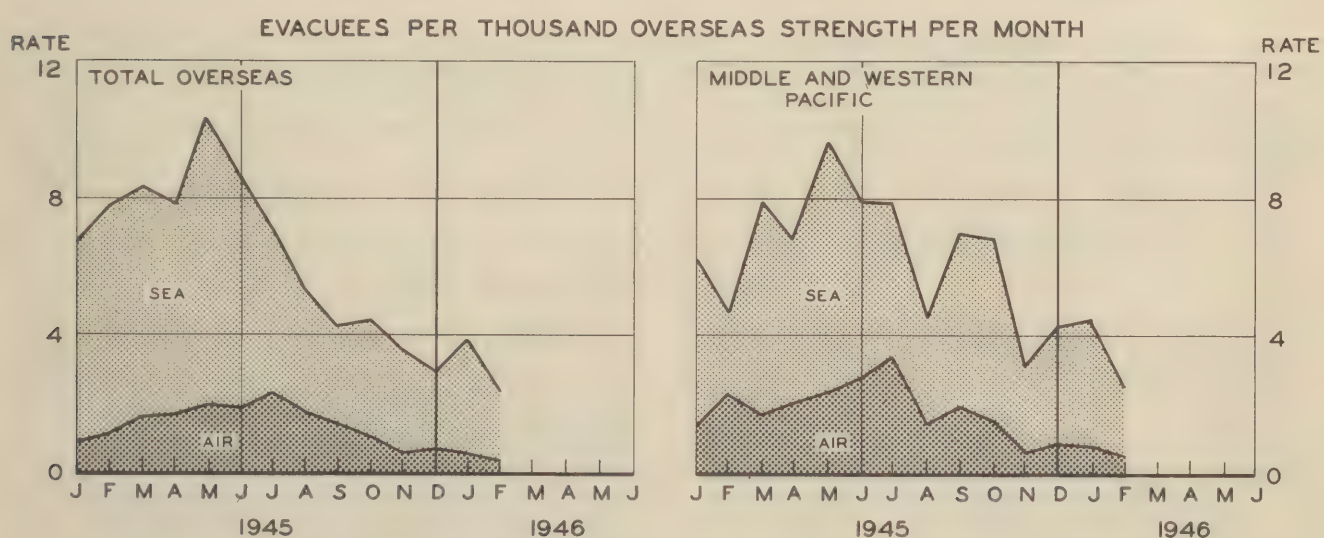
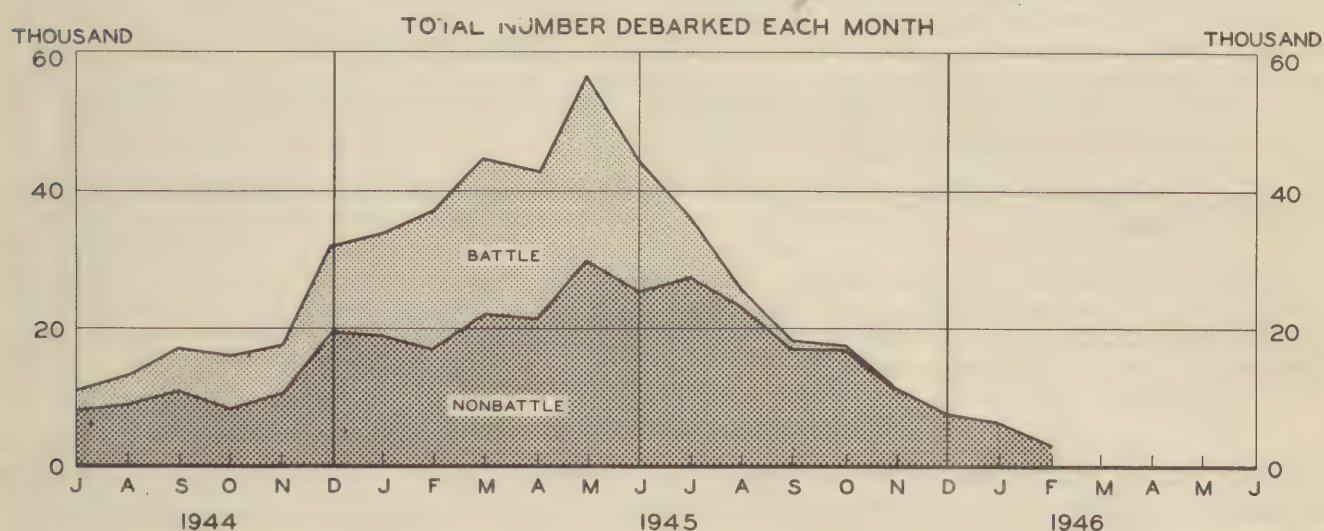
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## TREND OF EVACUATION FROM OVERSEAS

Only about 2,800 patients were returned to the Z/I from overseas during February, less than half the January total and lower than the count for any month since March 1943. Only 2,400 were returned by water and 400 by air, according to provisional counts. About 1,300 patients originated in the Pacific.

Strengths are still declining so rapidly in overseas theaters as to introduce extraneous variation into evacuation rates per 1,000 strength per month. Although the troop strength overseas declined appreciably during February, the number of patients received in the Z/I declined even more sharply, resulting in a fall in the rate of evacuation to 2.3 per 1,000, the lowest point since April 1944. Notifications to the Medical Regulating Officer show that there has been little change in the proportions of patients allocated to the main types. For February 33 percent were medical in classification, 41 percent surgical, 19 percent neuropsychiatric, and 7 percent convalescent.

## EVACUATION OF ARMY PATIENTS FROM OVERSEAS



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# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR

The contraction of the general hospital system currently under way made substantial progress during the month of February. Patient load declined by more than 21,000 from about 117,000 to less than 96,000 during the four-week period ending 22 February. More than eighteen thousand of this decrease is accounted for by net dispositions of overseas patients.

Only four installations were actually closed during the month, Schick General Hospital and the convalescent hospitals at Camp Edwards, Fort Story, and Camp Carson. However, patient load in the blocked hospitals decreased by more than 50 percent from approximately 29,000 to 14,000. It is noteworthy that less than 25 percent of the decline in patient load in the blocked hospitals represented the transfer of long-time patients to active hospitals, while 75 percent of the decline represented final dispositions.

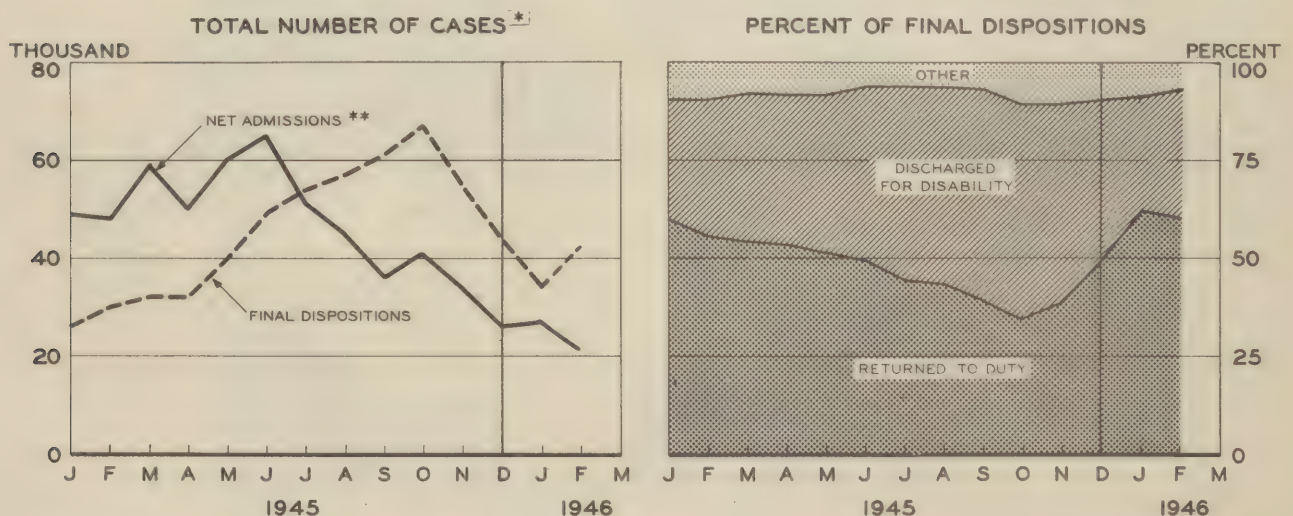
The planned closure of 34,500 general hospital beds and almost 6,500 convalescent beds during the first quarter of 1946 will involve the transfer from closing to active hospitals of approximately 5,000 patients who will continue to require treatment beyond 31 March. It is estimated that approximately 60 percent of these 5,000 patients will complete hospitalization by 30 June and more than 40 percent will still require hospitalization after that date. Prior to transfer, patients are therefore separated into these two categories and moved accordingly; that is, patients who will require hospitalization after 30 June are sent to hospitals slated to remain active beyond that date. This group of long-time patients consists largely of orthopedic surgery patients.

The reduced patient load in the blocked general and convalescent hospitals was reflected in reductions in bed authorizations of 13,000 in the general hospitals and 1,600 in the convalescent hospitals. Bed authorizations were further reduced by the elimination of debarkation spaces at Halloran General Hospital and at Camp Haan. In view of the sharp decrease in the evacuation of patients from overseas, it was found possible to concentrate debarkation activities in the New York Port at Camp Kilmer (with the exception of 75 locked ward beds at Mason General Hospital) and to terminate all debarkation activities in the Port of Los Angeles.

In accordance with the undertaking of the War Department to assist the Veterans Administration, the number of beds allotted for Veterans Administration beneficiaries was increased from 2,020 to 2,660. Bed credits were well ahead of occupancy, which rose by 100 to a total of 1,600 at the end of February.

In the station and regional hospitals, patient load decreased by approximately 4,000 and beds authorized declined correspondingly. The low ratio of patients remaining to effective beds in station hospitals reflects largely the low occupancy in hospitals under the jurisdiction of the Chief of Transportation which reflects, to some extent, the daily variations in patient load due to staging operations.

## ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS





# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

As a result of the promulgation of revised separation criteria on 1 February, the numbers of personnel assigned to ASF hospitals decreased considerably. Reductions in assigned personnel were much larger than reductions in requirements. The number of Medical Corps officers on duty decreased by 900 while requirements decreased by 350. Total personnel decreased by 14,000 while requirements decreased by 10,000. It is noteworthy that 12,000 of the reduction in assigned personnel was in military, and only 2,000 in civilian employees.

In contrast to the overall trend in personnel, the number of nurses assigned to ASF hospitals decreased at a slower rate than requirements. Corrective action is being taken to adjust the separation criteria.

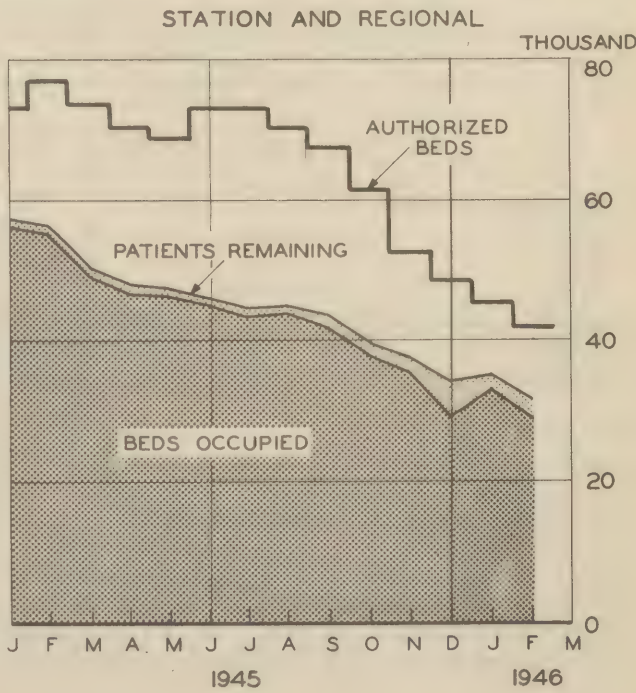
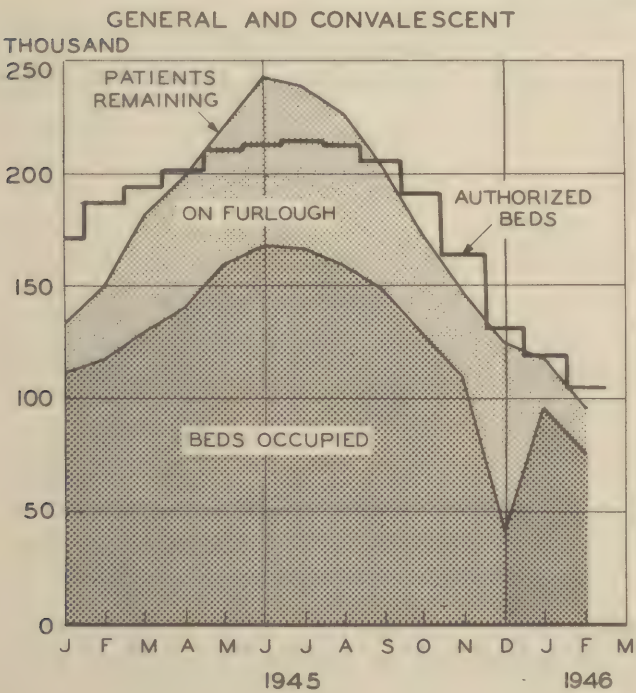
The reductions in personnel during February were even larger than indicated by the data. Movement of approximately 1,000 Medical Corps officers, 500 Dental Corps officers, and 300 Medical Administrative Corps officers to overseas theaters to replace men with long overseas service was initiated during February. A large number of this personnel, although shown as assigned to Zone of Interior installations, was on Preparation for Overseas Movement leave and not available for operating functions.

Personnel in excess of stated requirements exist in the blocked hospitals and in the station hospitals where reductions in operating personnel must necessarily lag behind continuous reductions in bed authorizations. Bed authorizations tend to reflect the instantaneous patient load at the end of the report period and fail to allow for the professional and administrative workload connected with the reduction of the patient load to the numbers reported.

### Summary:

- a. After lagging in January, the contraction of the general hospital system was accelerated during February, resulting in fifty-percent reductions in patient load and authorized patient capacity in the blocked hospitals.
- b. One general and three convalescent hospitals were closed during the month.
- c. Reductions in bed authorizations in regional and station hospitals kept pace with reductions in patient load except for hospitals under the jurisdiction of the Chief of Transportation.

## HOSPITAL CAPACITY AND PATIENT LOADS, Z/I HOSPITALS, 1945-1946





# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

d. Substantial reductions in operating military personnel were effected by the separation of military personnel who became eligible under the criteria announced on 1 February and by movement of large numbers of Medical Department officers overseas. Civilian personnel remained relatively intact.

### SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR End of February 1946

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages c/		
	Authorized	Effective a/	Number b/	Percent of Effective Beds		MC	ANC	Total
Total	146,003	134,487	127,148	94.5	105,335	-548	-1,526	-6,365
General	94,332	91,992	86,447	94.0	68,762	-240	-1,000	-3,616
Not Blocked	81,822	79,482	72,504	91.2	56,701	-86	-224	4,155
Blocked d/	12,510	12,510	13,943	111.5	12,061	-154	-776	-7,771
Convalescent	9,790	9,790	9,386	95.9	7,516	21	-15	183
Not Blocked	9,190	9,190	9,098	99.0	7,311	16	-17	290
Blocked d/	600	600	288	48.0	205	5	2	-107
Regional	17,232	13,786	15,550	112.8	13,896	-128	-225	-754
Station e/	24,649	18,919	15,765	83.3	15,161	-201	-286	-2,178

a/ Less debarkation beds and 20 percent dispersion in regional and station hospitals.

b/ Data exclude patients in triage at debarkation hospitals.

c/ Overages are indicated by a minus sign (-).

d/ Hospitals blocked for receipt of new patients; England scheduled for closure by 30 June; Deshon by 30 April; all others by 31 March 1946.

e/ Includes hospitals under the Chief of Transportation.

### BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS BY TYPE OF CARE AND TYPE OF HOSPITAL a/ End of February 1946

	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station b/
Total	142,663	127,148	86,447	9,386	15,550	15,765
General-Convalescent Care	83,616	75,684	66,517	9,167	-	-
Evacuees		63,272	55,021	8,251	-	-
Z/I		12,412	11,496	916	-	-
Regional-Station Care	49,533	43,434	16,393	204	14,499	12,338
Regional	8,097	8,182	3,871	-	4,020	291 c/
Station	41,436	35,252	12,522	204	10,479	12,047
Non-Army	9,514	8,030	3,537	15	1,051	3,427
POW	3,953	3,840	721	6	427	2,686
Civilians	2,509	2,159	1,071	8	423	657
Veterans Administration	2,660	1,586	1,395	1	179	11
Other	392	445	350	-	22	73

a/ Excludes debarkation beds and patients.

b/ Includes hospitals under the Chief of Transportation.

c/ Patients remaining in hospitals recently reduced from regional status.



STATISTICAL TABLES

RESTRICTED

STATISTICAL TABLES

Admission rates for selected diseases and for nonbattle injury in the United States and in overseas theaters are shown in the tables on the following pages. The rates include cases admitted to hospital or confined to quarters for a day or more, and have been derived from AGO Form 8-122 (formerly MD Form 86ab), both regular and telegraphic, submitted to The Surgeon General by each overseas theater or lesser command, and by posts, camps, and stations in the United States. Only the major overseas areas are shown separately, but the total overseas rates are based upon complete consolidations. The rates for each month average the experience of either four or five weeks depending upon the number of Fridays in the month. In each case they apply to all Army strength in the particular area: air, ground, and service. Rates computed from incomplete reports and those derived from the weekly telegraphic reports are distinguished from those based on final monthly reports. Admission rates for wounded in action, previously published on this page, are no longer shown. In their place appear separations of enlisted men for mental and physical disqualification under AR 615-361, covering disability, AR 615-368, covering undesirable habits and traits of character, and AR 615-369, covering inaptness, lack of required degree of adaptability, and enuresis. The series pertains to month of separation and is derived from reports of The Adjutant General through May 1945, and thereafter from preliminary reports submitted to The Surgeon General weekly on AGO Form 8-122. The latter have been adjusted to calendar months to conform with those reported by The Adjutant General.

The series shown for nonbattle injury is not entirely comparable throughout. In September 1944 a change in reporting provided that all readmissions for nonbattle injury be classified as disease admissions. The venereal disease rates derived from AGO Form 8-122 are generally higher than those based on the Monthly Venereal Disease Statistical Report. Venereal infections contracted prior to service have been excluded from the rates. Tentative neuropsychiatric admission rates are presented for 1944 and 1945. Not systematically reported on AGO Form 8-122 until late in 1943, these rates may not be as firm as those for communicable diseases. Malaria rates for the continental United States reflect only infections acquired in the United States; rates based on all admissions are much higher. They also measure diagnosed malaria only, but include both primary attacks and recurrences insofar as these are reported as malaria. A variable amount of malaria, differing from theater to theater, is at first reported as fever of undetermined origin. Many of these cases are later correctly diagnosed and enter into the rates. Since the system of reporting does not make it possible to subtract such cases from the undiagnosed category, some duplication between malaria and fever of undetermined origin continues to exist.

DISCHARGES OF ENLISTED MEN FOR DISABILITY

Year and Month		Number of Men Discharged			Discharges Per 1000 Enlisted Men Per Year		
		All Causes	Wounded a/	Neuro- psychiatric	All Causes	Wounded a/	Neuro- psychiatric
1942		62,013	30	26,091	20.8	0.0	8.8
1943		348,964	b/	138,609	56.2	b/	22.3
1944		205,091	b/	97,860	29.0	b/	13.8
1945	Jan-Jun	122,819	15,363	55,631	33.9	4.2	15.4
	Jul	34,312	6,660	10,534	55.1	10.7	16.9
	Aug	37,915	7,947	12,311	61.9	13.0	20.1
	Sep	40,346	10,676	12,640	71.1	18.8	22.3
	Oct	45,047	12,460	12,983	86.0	23.8	24.8
	Nov c/	35,060	8,990	8,260	83.4	21.4	19.6
	Dec c/	24,180	5,840	4,730	69.8	16.9	13.7
	Total	339,679	67,936	117,089	50.6	10.1	17.4
1946	Jan c/	14,770	3,450	3,370	54.4	12.7	12.4
	Feb c/	14,830	4,400	3,020	b/	b/	b/
	Mar						
Total to Date		985,347	b/	386,039	b/	b/	b/

a/ Discharge diagnosis b/ Not available.  
c/ Estimated from AGO Form 8-122 and adjusted to calendar months.

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# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Carib- bean	ETO a/	MTO	MIDPAC	WESPAC	Asiatic	AME
ALL DISEASE										
1942 Average	669	679	671	823	700	452	494	832	1,048	1,356
1943 Average	739	860	624	670	837	943	971	1,046	991	1,107
1944 Average	563	654	478	531	492	846	561	840	1,077	896
1945 Jan-Jun	569	631	426	562	538	726	448	1,006	707	587
Aug	478	621	346	531	501	645	466	891	796	620
Sep	442	539	288	465	456	649	465	674	587	539
Oct	443	507	268	467	482	768	347	571	385	434
Nov	474	542	274	424	555	941	257	581	365	364
Dec	506		245	442	664	1,055	285		440	352
Jul-Dec	467		311	493	520	724	448		607	521
Average	517		317	531	532	725	448		661	559
1946 Jan	600		320	519	773	1,072			462	
Feb	596 <u>b</u> /									
Mar										
Apr										
May										
Jun										

### NONBATTLE INJURY

1942 Average	91	125	152	107	110	96	104	178	80	162
1943 Average	80	133	182	105	100	149	114	171	84	140
1944 Average	67	113	127	68	97	138	111	139	96	99
1945 Jan-Jun	51	108	97	61	115	93	90	114	98	66
Aug	44	73	90	50	56	62	83	107	68	71
Sep	36	62	78	40	50	55	72	86	55	35
Oct	31	62	77	43	54	62	62	77	42	41
Nov	30	62	75	39	52	64	58	77	46	34
Dec	29		75	40	55	69	81		48	36
Jul-Dec	37		82	45	58	65	82		58	49
Average	44		91	54	94	86	87		80	59
1946 Jan	30		69	34	60	71			40	
Feb	29b/									
Mar										
Apr										
May										
Jun										

a/ Excluding Iceland

b/ Based on Incomplete Reports.



# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Carib- bean	ETO <u>a/</u>	MTO	MIDPAC	WESPAC	Asiatic	AME
ALL VENEREAL DISEASE										
1942 Average	29	32	7	74	38	36	12	32	64	86
1943 Average	26	34	3	56	43	56	5	15	52	68
1944 Average	33	42	5	33	35	111	5	7	51	60
1945 Jan-Jun	44	57	9	26	60	102	3	57	47	74
Aug	53	111	8	17	155	142	4	77	40	73
Sep	57	110	7	18	154	213	4	68	40	77
Oct	56	117	9	20	168	287	3	71	42	76
Nov	60	142	10	38	208	456	2	91	55	86
Dec	50		10	35	224	417	5		81	81
Jul-Dec	54		8	23	166	213	4		46	78
Average	49		9	25	100	132	4		46	76
1946 Jan	71		17	58	233	382			101	
Feb	67 <u>b/</u>									
Mar										
Apr										
May										
Jun										

### DIAGNOSED MALARIA

1942 Average	0.6	33	0	99	0	11	12	52	165	136
1943 Average	0.2	96	0	37	3	54	208	245	181	123
1944 Average	0.2	38	-	14	9	62	43	53	174	59
1945 Jan-Jun	0.1	19	0	9	8	23	5	58	37	11
Aug	0.1	12	-	8	3	15	2	29	31	13
Sep	0.1	11	-	9	1	8	3	25	29	12
Oct	0.1	11	-	9	1	3	1	24	21	11
Nov	0.1	16	-	7	0	2	1	35	18	7
Dec	0.1		-	10	0	1	1		22	3
Jul-Dec	0.1		0	9	2	13	3		27	11
Average	0.1		0	9	6	21	4		32	11
1946 Jan	0.1		-	8	0	0			21	
Feb	0.1									
Mar										
Apr										
May										
Jun										

a/ Excluding Iceland.

b/ Based on incomplete reports.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.



# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command.								
		Total	Alaska	Carib- bean	ETO <u>a/</u>	MTO	MIDPAC	WESPAC	Asiatic	AME
COMMON RESPIRATORY AND INFLUENZA										
1942 Average	243	163	244	113	291	151	89	149	152	202
1943 Average	247	181	222	99	409	142	86	108	159	201
1944 Average	147	132	188	81	142	162	85	83	176	219
1945 Jan-Jun	145	115	177	95	112	132	65	128	139	132
Jul	77	93	90	150	56	61	99	180	182	108
Aug	79	96	85	105	66	69	91	151	157	115
Sep	72	87	68	117	63	66	60	123	123	116
Oct	79	84	47	140	72	74	51	105	84	97
Nov	101	75	53	131	69	61	24	100	62	64
Dec	160		44	128	105	90	19		72	102
Jul-Dec	90		69	127	68	68	73		121	104
Average	116		131	109	96	115	68		138	127
1946 Jan	172		61	178	135	154			87	
Feb	189 <sup>b/</sup>									
Mar										
Apr										
May										
Jun										

### DIARRHEA AND DYSENTERY

1942 Average	8	30	5	19	17	33	34	59	123	196
1943 Average	12	66	8	16	12	132	43	70	146	170
1944 Average	9	38	3	13	13	54	28	55	181	115
1945 Jan-Jun	7	35	2	15	16	22	22	104	98	73
Jul	6	45	1	15	20	30	24	106	151	120
Aug	8	38	1	11	17	25	12	75	122	106
Sep	7	27	1	10	9	15	13	51	79	87
Oct	4	20	0	7	5	11	11	38	46	58
Nov	4	16	-	10	4	10	4	25	42	44
Dec	4		-	20	4	7	1		50	34
Jul-Dec	6		1	12	12	21	14		89	87
Average	6		1	14	14	22	19		94	79
1946 Jan	4		1	10	3	6			54	
Feb	3 <sup>b/</sup>									
Mar										
Apr										
May										
Jun										

<sup>a/</sup> Excluding Iceland.



# STATISTICAL TABLES

## STATISTICAL TABLES (Continued)

### ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Carib- bean	ETO <u>a/</u>	MTO	MIDPAC	WESPAC	Asiatic	AME
FEVER OF UNDETERMINED ORIGIN										
1943 Average	<u>c/</u>	52	0	64	1	75	19	166	71	21
1944 Average	<u>c/</u>	38	1	34	2	71	20	88	131	27
1945 Jan-Jun	<u>c/</u>	28	0	12	6	42	7	100	70	28
Jul	<u>c/</u>	30	1	7	5	57	10	86	102	50
Aug	<u>c/</u>	22	0	6	5	58	5	38	91	59
Sep	<u>c/</u>	12	-	8	3	41	3	10	76	49
Oct	<u>c/</u>	9	-	10	2	28	4	8	52	27
Nov	<u>c/</u>	7	-	16	2	25	1	6	45	25
Dec	<u>c/</u>		-	22	3	20	1		50	15
Jul-Dec	<u>c/</u>		0	10	4	47	6		73	44
Average	<u>c/</u>		0	11	5	43	7		72	34
1946 Jan	<u>c/</u>		-	21	3	14			52	
Feb										
Mar										
Apr										
May										
Jun										

### NEUROLOGICAL AND PSYCHIATRIC DISORDERS

1944 Average	36	43	12	21	52	43	27	48	20	25
1945 Jan-Jun	48	33	12	24	30	27	26	60	22	15
Jul	39	18	11	23	10	12	25	38	25	10
Aug	37	17	16	18	8	14	21	35	22	12
Sep	26	14	10	15	7	12	30	24	18	7
Oct	23	11	8	11	6	12	19	15	17	11
Nov	23	10	8	10	5	10	16	14	11	8
Dec	21	-	12	11	5	14	10	-	13	11
Jul-Dec	29	-	11	15	7	13	22	-	19	10
Average	38	-	12	20	22	23	24	-	21	13
1946 Jan	24	-	16	6	6	14	-	-	11	-
Feb										
Mar										
Apr										
May										
Jun										

a/ Excluding Iceland.

b/ Based on incomplete reports.

c/ Not available.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.



